

## Caring for immigrant women

Physicians' roles range from detective work to advocacy [see also p 433](#)

Susan L Ivey

Center for Family and  
Community Health  
140 Warren Hall  
School of Public Health  
University of California  
Berkeley, CA  
94720-7360

Shotsy Faust

Family nurse practitioner  
Refugee Clinic  
San Francisco General  
Hospital Medical Center

Correspondence to:  
Dr Ivey  
sliveymd@socrates.  
berkeley.edu

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The movement of people across national borders is one of the critical issues of our time.<sup>1</sup> Large numbers of Mexican Americans cross the US border, legally and illegally, to seek better employment and living conditions, and some are fleeing for their lives. Various ethnic groups make up the large and growing Asian American population. Vietnamese, Cambodian, Laotian, Burmese, and other Southeast Asian refugees have sought asylum here, in flight from political regimes that threaten life and freedom. Immigrants from the Philippines and India often come to reunite with family or to follow "the American dream." The fall of the former Soviet Russia; ethnic cleansing and the war in Bosnia; the continued conflict in Iraq; religious oppression in Iran and Afghanistan; and drought, famine, and war in Ethiopia and Eritrea have all brought newcomers to the United States. Such immigration has led to rapid demographic change, illustrated by data emerging from the 2000 census.<sup>2,3</sup> As of 2000, the California population comprised 53.3% minorities and 46.7% whites, joining New Mexico and Hawaii as states in which minority groups make up more than 50%.<sup>2</sup> This immigration poses unique challenges to health care providers, including physicians and nurse practitioners, nurses and mental health workers of all types (social workers, psychologists, counselors), particularly in providing comprehensive medical care to immigrant women.

Women made up 53.5% of the 1998 legal immigrants, and their median age was 29 years. These women, who are often in their prime reproductive years, arrive with a plethora of unique health care needs. More than 10% (75,000) of the women were older than 45 years, and these older women needed a different spectrum of health services.<sup>4</sup> Nearly all clinicians will see these patients in their practice, especially those who work in states with high immigration rates. What challenges do health care professionals face?

All recent immigrants have some stress related to migration and acculturation.<sup>5,6</sup> In addition, most of them face a bewildering medical system that has complex and often unfamiliar funding mechanisms and access rules. The 1996 immigration and welfare reform laws restricted most federal benefits to citizens.<sup>7</sup> Since then, immigrants often fear that use of the health system and various types of coverage such as Medicaid or Medicare will result in expenses to their sponsors or deportation, even when their US-born children qualify for coverage. Thus, a specter—fear and lack of trust—often hangs over each clinical visit. Physicians may be unaware of these unspoken fears that profoundly affect each clinical encounter. Fear of the cost

of care may also prevent many from seeking care until a health condition becomes acute or even emergent and often more expensive to treat.

All of these factors converge on provider and patient as they initially meet one another, challenging the establishment of a therapeutic relationship.<sup>8</sup> Although knowledge of the types of problems faced, epidemiologic factors, and the sequelae of migration and trauma are important, most clinicians—as medical experts but cultural novices—must enter the clinical relationship with a kind of humility that may be unfamiliar. By approaching the patient in a culturally humble manner, clinicians become not just "medical experts" but students of a patient's culture. By forming a partnership with patients in a totally new way, clinicians stand a better chance of learning the true concerns of patients and how to address those concerns. Conscientious attention to barriers such as language and interpretation needs, lack of insurance, and lack of specialists with specific skills (such as mental health providers) can improve use patterns and outcomes for patients as they learn to negotiate the US health system.

With that scenario in mind, we offer in this issue of *wjm* a framework for approaching immigrant women presenting for care (see p 433). Unfortunately, there are no national protocols to guide us in caring specifically for immigrants, other than for tuberculosis testing.<sup>9</sup> Few immigrants who are seen for care arrive with their history and



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Immigrant women have unique health care needs

medical records in hand. Clinicians become detectives of sorts in determining what care is needed for both immediate symptom relief and ongoing prevention and screening.

All physicians and nurse-clinicians need to have cultural competence training and deserve better evidence-based practice guidelines for delivering care to immigrants than are currently available. Medical schools, nursing schools, and residency training programs need to promote such training.<sup>10</sup> Some medical schools have introductory policy courses that emphasize gaps in the health system.<sup>11</sup> In addition to cultural competence training, health care professionals of all types must advocate for appropriate translation and interpretation services locally.<sup>12</sup> Many pathways exist for providing this most necessary of services. Current law also mandates that hospitals provide these services. Physicians need training to maximize effectiveness when working with interpreters.<sup>10</sup> Having family members translate is not an acceptable solution because it causes potential stress, and it can introduce bias in interpretations of symptoms and history. By learning about barriers to care faced by patients who have recently immigrated—language, access, and coverage—physicians and other health care providers better understand how the health system works, or fails to work, for vulnerable groups. They are in the position to act as their patients' advocate.

On a national level, physicians and nurse-clinicians should work toward more compassionate policies for funding the provision of services for our newest US residents. Whereas the 1989 "antidumping" law ensures access to the emergency department,<sup>13</sup> we do not want to confine immigrants (or ourselves) to a system that discourages adequate preventive care or early treatment while ensuring full access to acute care services.<sup>14</sup> There has to be a more rational policy solution toward the integration of newcomers to our health system.

**Authors:** Susan L. Ivey is a family and emergency physician and a researcher with the School of Public Health, Berkeley, CA. She is assistant clinical professor in the University of California, Berkeley–University of California, San Francisco Joint Medical Program. Shotsy Faust is associate clinical professor in the department of family health nursing at University of California–San Francisco.

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